EXHIBIT 3

DATE : 02/22/2016
TIME : 10:50:12PM

Inmate Medical Form
CREEK COUNTY SHERIFFS OFFICE

Name: **FOUTCH, RUSSELL TED** Date Of Birth: [redacted] Date: **02/22/2016**
Booking #: **54293** Jacket: **138388** Race/Sex **W/M** Intake Date: **02/22/2016** Time: **22:50**

Answer	Question	#
No	Is inmate unconscious?	1
No	Does inmate have any visible signs of trauma, illness, obvious pain or bleeding, requiring immediate emergency or doctor`s care?	2
No	Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread though the facility?	3
No	Any signs of poor skin condition, vermin, rashes or needle marks?	4
No	Does inmate appear to be under the influence of drugs or alcohol?	5
No	Any visible signs of alcohol or drug withdrawal?	6
No	Does inmates behavior suggest the risk of suicide or assault?	7
No	Is inmate carrying medication?	8
No	Does inmate have any physical deformities?	9
No	Does inmate appear to have psychiatric problems?	10
No	Allergies	11
No	Arthritis	12
No	Asthma	13
No	Diabetes	14
No	Epilepsy	15
No	Fainting Spells	16
No	Venereal Disease	17
No	Other (specify)	18
No	Have you recently been hospitalized or treated by a doctor?	21
Yes	Do you currently take any medication prescribed by a doctor? **Yes.**	22
No	Are you allergic to any medication?	23
Yes	Do you have any handicaps or conditions that limit activity? **Yes. Bad hip**	24
No	Have you ever attempted suicide or are you thinking about it now?	25
No	Do you have any problems when you stop drinking or using drugs?	26
No	Do you have a special diet prescribed by a physician?	27
No	Do you have any problems or pain with your teeth?	28
No	Do you have any other medical problems we should know about?	29
No	Hepatitis	31
No	Heart Condition	32
No	High Blood Pressure	33
Yes	Psychiatric Disorder **Yes. Depression and anixety**	34
No	Seizures	35
No	Tuberculosis	36
No	Ulcers	37
No	Is the inmate bleeding profusely	38
No	How Injury was Received.	39
No	Description of any recent physical injury	40
No	How injury was received	41
No	Perscriptions/Medical Treatments/Medical Programs	42

NOTE: An * means the question was not answered.

Form_InmateMedicalRevised 0980

DATE : 02/22/2016
TIME : 10:50:12PM

Inmate Medical Form
CREEK COUNTY SHERIFFS OFFICE

Name: **FOUTCH, RUSSELL TED** Date Of Birth: [redacted] Date: **02/22/2016**
Booking #: **54293** Jacket: **138388** Race/Sex **W/M** Intake Date: **02/22/2016** Time: **22:50**

Answer	Question	#
No	Description of Injury Treatment	43
No	Any medical condition that could adversely affect your health if you are booked in to the Creek county jail?	44
Yes	Are you now or have you ever been treated by a mental health provider? **Yes.**	45
Yes	Have you ever been booked into Creek County Jail Before? **Yes.**	46
No	HIV/AIDS	47
No	Are you allergic to any FOOD?	48
Yes	If you are on any medications, this is to inform you that YOU must provide the medications in a legal and current prescription bot **Yes. DOC**	49
Yes	are you a DOC inmate? what facility **Yes. Oklahoma Reformatory at Granite**	50
No	Have you been involved in an altercation or vehicel colision	60

Russell Foutch
Inmate's Signature

12:00:00 AM
Officer's Signature

NOTE: An * means the question was not answered.

Form_InmateMedicalRevised *0980*

Authorization and Consent

DATE : 02/22/2016
TIME : 10:50:30PM

CREEK COUNTY SHERIFFS OFFICE

From: **CREEK COUNTY SHERIFFS OFFICE**
316 EAST LEE AVENUE
SAPULPA, OK. 74066
Phone: **(918) 227-6374** Fax:

To: _____
Phone: _____
Fax: _____

Print Name: **FOUTCH, RUSSELL TED**

Social Security Number [redacted]

Date Of Request **02/22/2016**

Pharmacy: _____

City & State _____

Booking #: **54293**
Jacket: **138388**

I, the below signed and above printed, being competent, 18 yrs of age or older and duly authorized, do willfully and voluntarily authorized to the above stated to release the following from Medical records to CREEK COUNTY SHERIFFS OFFICE. I specifically authorize the release of my drug, alcohol and or mental health treatment records.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) receiving it and is no longer protected by the Federal Privacy Regulations. I further release all employees of the CREEK COUNTY SHERIFFS OFFICE from any responsibility from such.

I understand that I may revoke this authorization by notifying the above intended in writing of my desire to revoke. This cancellation will not apply to information already released based on this authorization.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

____Discharge Summary
____X-Ray
____Lab Report
____Special Consults
____Progress Notes
____History & Physical
____Verify Medications
____Psych. Reports
____CT / MRI
____Path Report
____Surgical Reports
____ALL OF THE ABOVE

I further understand the information and authorization for release may contain information that indicates I have a communicable disease. This information has been disclosed to you from records protected by Federal / State confidentiality rules. The Federal / State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person whom it pertains or as otherwise permitted by 42 CER part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal / State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

X _____ Signature DOB: [redacted]

X _____ Witness
(If under the age of 18)

Important Notice: The information contained throughout this form (facsimile) above is privileged and confidential, intended only for the individual designated above. Others are hereby notified that disclosure, copying distribution or taking action based on the content of this information is strictly prohibited. If you receive the form erroneously transmitted to you, it should be returned to the sender by US Mail or authorized by sender to destroy.

TURN KEY HEALTH

DOC

MEDICAL INTAKE FORM

NAME: Foutch, Russell DOB: [redacted] SS/INMATE#

HEALTH INSURANCE: ☐ YES ☒ NO CARRIER/POLICY NUMBER:

☒ MALE ☐ FEMALE

RACE: ☒ WHITE ☐ BLACK ☐ ASIAN ☐ AMERICAN INDIAN ☐ HISPANIC

OTHER

SENT FOR A FIT? ☐ YES ☒ NO REASON:

ALLERGIES ~

MEDICATION ☐ YES ☒ NO WHAT MEDICATION:

INMATE CHECKED FOR HEAD LICE? ~ YES TREATMENT NEEDED? YES ~ NO

ANY INJURIES TO REPORT DUE TO ARREST OR BOOKING? YES NO What?

WEAR GLASSES, CONTACTS, DENTURES, PARTIAL, HEARING AIDS, OR USE ANY PROSTHESIS OR MEDICAL DEVICE?

IF SO WHAT? glasses HAVE ON PERSON? N PLACED IN PROPERTY? N

VITALS: TEMP 97° B/P 142/90 PULSE 65 O2SAT 95 WEIGHT 208

LIST ALL CURRENT MEDICATIONS INCLUDE DOSAGE, FREQUENCY, LAST TIME TAKEN AND PHARMACY?

Remeron 45mg ½ po@HS Risperdol 2mg ½ at night

CSR - granite OK

MEDICAL ILLNESS: CHECK ANY CURRENT OR PAST CONDITIONS:

☐ HEART ATTACK/CARDIAC DISEASE EXPLAIN WHEN

☐ HIGH B/P

☐ CANCER/ONCOLOGY- TYPE

☐ LUNG DISEASE

☐ STROKE

☐ ASTHMA

☐ DIABETES INSULIN CURRENT FSBS EXPLAIN

☒ SURGERIES (R) hip fx 2014

☐ SEIZURE DATE OF LAST SEIZURE

☐ HIV/AIDS HOW LONG? CURRENT MEDS? LAST LAB

☐ STD'S TYPE

☐ MAJOR DENTAL CONDITIONS

☐ HEPATITIS-TYPE: HOW LONG?

HISTORY OF TB / POSITIVE TB SKIN TEST? WHEN WHERE TREATMENT

HAVE YOU RECENTLY EXPERIENCED: CHRONIC COUGH - COUGHING UP BLOOD – LETHARGY - BODY WEEKNESS - MORE THAN 10 LBS WEIGHTLOSS IN THE LAST MONTH – LOSS OF APPETITE - FEVER, -NIGHT SWEATS? IF YES TO ANY, EXPLAIN:

APPEARANCE – SWEATING – TREMORS – ANXIOUS – DISHEAVELED – UNREMARKABLE

BEHAVIOR – NERVOUS – DISORDERLY – INSENSIBLE – APPROPRIATE

STATE OF CONSCIOUSNESS – ALERT – LETHARGIC – UNDER THE INFLUENCE

BREATHING – LABORED – PERSISTENT COUGHING – HYPERVENTILATING – UNREMARKABLE

EASE OF MOVEMENT – DEFORMITIES – UNSTABLE GAIT – ASSITIVE DEVICE – UNREMARKABLE

SKIN - DO YOU CURRENTLY HAVE: RASHES – SORES – WOUNDS – JAUNDICE – SKIN CONDITIONS – BRUISES - TRAUMA MARKINGS - NEEDLE MARKINGS - RECENT TATTOOS? WHERE/CONCERNS? _____

FEMALE HEALTH

ARE YOU PREGNANT NOW? ☐ YES ☐ NO ☐ DON'T KNOW LAST MENSTRAUL CYCLE _____
IF PREGNANT EDD? _____ # OF PREGNANCIES _____ # OF LIVE BIRTHS _____
PROBLEM IN PREGNANCIES? _____ HIGH RISK ☐ YES ☐ NO (TYPE OF DELIVERY) _____
OB/GYN NAME: _____ PHONE# _____
LAST VISIT DATE: _____ NEXT APPT SCHEDULE: _____

MENTAL HEALTH

HAVE YOU EVER HAD A MENTAL ILLNESS? ☐ YES ☐ NO
EXPLAIN Anxiety + Depression
ARE YOU CURRENTLY SEEN BY MENTAL HEALTH PROFESSIONAL? ☑ YES ☐ NO
WHO? Granite
HAVE YOU EVER TAKEN ANY MENTAL HEALTH MEDS? ☒ YES ☐ NO
WHAT See front
ATTEMPTED SUICIDE? ☐ YES ☑ NO EXPLAIN: _____
ANY CURRENT SUICIDAL THOUGHTS? ☐ YES ☒ NO EXPLAIN: _____

ARE YOU USING OR HAVE YOU EVER USED ANY OF THE FOLLOWING? DATE OF LAST USE?

☐ TRANQUILIZERS _____
☐ OPIATES _____
☐ BARBITUATES _____
☐ LSD/HALLUCINOGENS/PCP _____
☐ MARIJUANA _____
☒ AMPHETAMINE/SPEED 2014
☐ GLUE/SOLVENT/ INHALANT _____
☐ HEROIN _____
☒ CRACK / COCAINE _____
☒ ALCOHOL 2014
☐ OTHER _____

HAVE YOU EVER HAD OR ARE YOU CURRENTLY HAVING ANY WITHDRAWAL SYMPTOMS WHEN YOU STOPPED DRUGS OR ALCOHOL? ☐ YES ☒ NO EXPLAIN: _____

OTHER COMMENTS OR PHYSICAL FINDINGS:

RECOMMENDED HOUSING BASED ON MEDICAL/MENTAL HEALTH EVALUATION:

☐ TRANSPORT TO HOSPITAL
☑ RECOMMENDED GENERAL POPULATON
☐ SUICIDE PRECAUTIONS
☐ RECOMMENDED MEDICAL HOUSING / ISOLATION DUE TO: _____

INSTRUCTED ON HOW TO ACCESSS MEDICAL/ MENTAL HEALTH CARE? ☒ YES ☐ NO

MEDICAL EVALUATION PREFORMED BY: _____ LPN

MEDICAL EVALUATION DATE: 2-23-16

TURN KEY HEALTH

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF PROTECTED HEALTH INFORMATION

Patient's name: Foutch, Russell **Date of birth:** _____

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following (please provide complete address):

Name of Facility or Person to receive PHI:
_____
Address: _____
Phone no.: _____
Fax no.: _____

Name of Facility or Person to Release PHI:
Gina Cooper
Address: _____
Phone no.: 918-230-7980
Fax no.: _____

The type of information to be disclosed:

Evaluations_____
Diagnosis_____ All
Treatment Plan _____
Other _____

Medical/Hospital Records_____
Psychological Test Results _____
Medical Test Results _____
Lab results_____

Mental Health Record Summary_____
Psychotherapy Notes _____
X-ray reports _____

The purpose of such disclosure:

Ongoing Treatment_____ Medical Care_____ Consultation_____
Evaluation _____ Transfer _____ Coordination of Care_____

The designated information about me___ may ___ may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. The above designated person ___may ___ may not discuss by telephone the content of the information released.

This consent is in effect until release from custody. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that the information authorized for release may include records related to mental health, or drug, substance or alcohol abuse. I also,understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in **section 12.43.218 CRS** and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

I understand that information I have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the U.S. Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the U.S. Department of Health or by law.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Signature of Patient: _____ **Date:** _____

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

7-8-16

CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL/PSYCHIATRIC INFORMATION

Patient's Name: Foutch, Russell

DOB: [redacted] Social Security Number: [redacted]

I THE UNDERSIGNED, DO HEREBY AUTHORIZE OSR Granite Penitentary Rx list 580-480-3987

TO RELEASE INFORMATION CONCERNING ANY MEDICAL OR MENTAL HEALTH TREATMENT RECEIVED INCLUDING X-RAY RESULTS, LABS, MEDICATIONS, TREATMENTS AND ORDERS OR ANY OTHER MEDICAL RELATED DATA FOR THE PURPOSE OF CONTINUED MEDICAL OR MENTAL HEALTH TREATMENT.

INFORMATION WILL BE RELEASED TO THE MEDICAL DEPARTMENT OF:
Creek County Jail (CCCJC)
9175 Riddleview Rd. Tulsa, OK.
PHONE # 918-227-6375 FAX # 918-227-6376

NOTICE
(63O.S. 1992, 1-502.2B)

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE, NON-COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, SICKLE CELL, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS AIDS, AND DRUG AND ALCOHOL ABUSE.

I understand that the records requested may be protected under 42 C.F.R. Part 2 governing Alcohol and Drug Abuse Patient records, the Health Insurances Portability and Accountability Act of 1996(HIPPA) 45 C.F.R. Parts 160 & 164, State Confidentiality laws and regulations and can not be released without any consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulations.

INFORMATION MAY BE RELEASED TO THE ABOVE NAMED PERSONS UNTIL RELEASED FROM CUSTODY:

SIGNATURE OF PATIENT: [signature] DATE: 2-23-16

WITNESS (1) [signature] 2-23-16

WITNESS (2) _____

(SIGNATURE BY MARK MUST HAVE 2 WITNESSES)

NOTICE TO ABOVE RECIPIENTS

CERTAIN STATUTES, STATES AND FEDERAL, MAY PROHIBIT FUTHER DISCLOSURES OR RELEASE OF THE ABOVE INFORMATION WITHOUT SPECIFIC WRITTEN CONSENT FOR RELEASE FROM THE PERSON(S) ABOUT WHOM IT PERTAINS. THIS "CONSENT FOR RELEASE OF CONFIDENTAL INFORMATION" IS NOT INTENDED TO AUTHORIZE FURTHER RELEASE OR DISCLOSURE, NOR CONSTITUTE A WAVIER OF SUCH OTHER STATUTES.

* * * Communication Result Report (Feb. 23. 2016 1:07PM) * * *

1) CREEK COUNTY JUSTICE CTR-BOOKING
2)

Date/Time: Feb. 23. 2016 1:06PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
7580	Memory TX	15804803987	P. 1	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

CONSENT FOR RELEASE OF CONFIDENTIAL MEDICAL/PSYCHIATRIC INFORMATION

Patient's Name: Foutch, Russell

DOB: [redacted] Social Security Number: [redacted]

I THE UNDERSIGNED, DO HEREBY AUTHORIZE OSR Granite Reformatory Rx/Ist 580-480-3987

TO RELEASE INFORMATION CONCERNING ANY MEDICAL OR MENTAL HEALTH TREATMENT RECEIVED INCLUDING X-RAY RESULTS, LABS, MEDICATIONS, TREATMENTS AND ORDERS OR ANY OTHER MEDICAL RELATED DATA FOR THE PURPOSE OF CONTINUED MEDICAL OR MENTAL HEALTH TREATMENT.

INFORMATION WILL BE RELEASED TO THE MEDICAL DEPARTMENT OF:
Creek County Jail (CCJC)
917 S Kiddy Ives Rd. Kellyville OK.
PHONE # 918-227-6375 FAX # 918-227-6376

NOTICE
(63O.S. 1992, 1-502.2(B))

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE, NON-COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, HEPATILIS, SICKLE CELL, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS AIDS, AND DRUG AND ALCOHOL ABUSE.

I understand that the records requested may be protected under 42 C.F.R. Part 2 governing Alcohol and Drug Abuse Patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) 45 C.F.R. Parts 160 & 164, State Specific laws and regulations and can not be released without my consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of this records without my specific written consent or when otherwise permitted by such regulations.

INFORMATION MAY BE RELEASED TO THE ABOVE NAMED PERSONS UNTIL RELEASED FROM CUSTODY:

SIGNATURE OF PATIENT: [signature] DATE: 2-23-16

WITNESS (1) _____

WITNESS (2) _____
(SIGNATURE BY MARK MUST HAVE 2 WITNESSES)

NOTICE TO ABOVE RECIPIENTS
CERTAIN STATUTES, STATES AND FEDERAL, MAY PROHIBIT FURTHER DISCLOSURES OR RELEASE OF THE ABOVE INFORMATION WITHOUT SPECIFIC WRITTEN CONSENT FOR RELEASE FROM THE PERSON(S) ABOUT WHOM IT PERTAINS. THIS "CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION" IS NOT INTENDED TO AUTHORIZE FURTHER RELEASE OR DISCLOSURE, NOR CONSTITUTE A WAIVER OF SUCH OTHER STATUTES.

MEDICAL PROGRESS NOTE FORM

(ALL PATIENT ENCOUNTERS REQUIRE SOAPE FORMAT)

NAME: Foutch, Russell DOB: [redacted] INMATE#

ALLERGIES NKDA

DATE/TIME	CLINICAL NOTE
2/23/16 1451	Meds list received from okla home state reformatory. Provider notified and gave orders to continue meds that met the facility's protocol (see Mar for meds)

TURN KEY HEALTH

Oklahoma Department of Corrections

FOUTCH, RUSSELL
OK DoC Offender ID [redacted]
[redacted] (49) M Caucasian
Oklahoma State Reformatory

Medication	Start Date	End Date
Rx Lamictal [lamotrigine] 25 mg tablet oral	2/20/2016	5/19/2016
4 tablet(s) Before bed for 90 Days	2/20/2016	5/19/2016
Rx DiphenhydrAMINE Hydrochloride [diphenhydrAMINE] 50 mg capsule oral	2/15/2016	5/14/2016
1 capsule(s) Before bed for 90 Days	2/15/2016	5/14/2016
Rx Mirtazapine [mirtazapine] 45 mg tablet oral	2/15/2016	5/14/2016
1 tablet(s) Before bed for 90 Days	2/15/2016	5/14/2016
Rx Risperidone [Risperidone] 1 mg tablet oral	2/15/2016	5/14/2016
2 tablet(s) Before bed for 90 Days	2/15/2016	5/14/2016
Rx Celexa [citalopram] 20 mg tablet oral	1/7/2016	4/5/2016
1 tablet(s) Before bed for 90 Days	1/7/2016	4/5/2016

Notes: .

SICK CALL REQUEST FORM

INMATE NAME: Russell Fortes DOB: _____ INMATE NUMBER: [redacted]

DATE: 3-4-16 FACILTY: CCJC LOCATION/POD: E POD

REASON FOR REQUEST:

I have a toothache abgessed forth

1. INMATES ACCESSING MEDICAL, MENTAL HEALTH, DENTAL OR PHARMACEUTICAL SERVICES WILL BE CHARGED IN ACCORDANCE WITH OKLAHOMA STATUTES.
2. INMATES WILL NOT BE DENIED MEDICAL CARE DUE TO THE INABILITY TO PAY OR DUE TO INSUFFICIENT FUNDS IN THEIR INMATE ACCOUNT.
3. FEES FOR MEDICAL SERVICES WILL BE DEDUCTED DIRECTLY FROM AN INMATE'S ACCOUNT. IF THERE ARE INSUFFICIENT FUNDS IN THE ACCOUNT, THE FEES WILL BE DEBITED AND THE ACCOUNT WILL SHOW A NEGATIVE BALANCE. ANY MONEY DEPOSITED INTO AN ACCOUNT WITH A NEGATIVE BALANCE WILL BE USED TO SATISFY THE DEBT WITH THE FACILITY PRIOR TO BEING AVAILABLE FOR COMMISARY SERVICES.

INMATE SIGNATURES ARE REQUIRED PRIOR TO SUBMITTING REQUESTS, AND SIGNATURES ACKNOWLEDGE UNDERSTANDING OF THE SICK CALL PROCESS.

Russell Fortes

INMATE SIGNATURE _____ DATE

MEDICAL STAFF USE ONLY BELOW THIS BOX

RECEIVED BY MEDICAL:

MEDICAL SIGNATURE 3/5/16 0700 DATE/TIME

~~4/6/2015~~ 9/8 662 6170

ACTION TO BE TAKEN:

☐ SCHEDULE FOR SICK CALL ☐ SCHEDULE FOR PROVIDER CLINIC ☐ WRITTEN RESPONSE TO INQUIRY

☒ OTHER: need Doc Numbers to Rx to Jess Dunn

MEDICAL RESPONSE:

Pt was seen and treated in clinic

MEDICAL SIGNATURE 3/5/16 DATE/TIME

TURN KEY HEALTH

INMATE NAME: Russell Fautch

DATE: 3-4-2016 DOB: [redacted]

FACILTY: CCJC INMATE NUMBER: (DOC) [redacted]

LOCATION/POD: E-Pod

REASON FOR REQUEST:

I here throbbing Pain in my upper left teeth my check is swollen and It hurts bad I need "Ibuprofen" please or something of the sort. Thank you

1. INMATES ACCESSING MEDICAL, MENTAL HEALTH, DENTAL OR PHARMACEUTICAL SERVICES WILL BE CHARGED IN ACCORDANCE WITH OKLAHOMA STATUTES.
2. INMATES WILL NOT BE DENIED MEDICAL CARE DUE TO THE INABILITY TO PAY OR DUE TO INSUFFICIENT FUNDS IN THEIR INMATE ACCOUNT.
3. FEES FOR MEDICAL SERVICES WILL BE DEDUCTED DIRECTLY FROM AN INMATE'S ACCOUNT. IF THERE ARE INSUFFICIENT FUNDS IN THE ACCOUNT, THE FEES WILL BE DEBITED AND THE ACCOUNT WILL SHOW A NEGATIVE BALANCE. ANY MONEY DEPOSITED INTO AN ACCOUNT WITH A NEGATIVE BALANCE WILL BE USED TO SATISFY THE DEBT WITH THE FACILITY PRIOR TO BEING AVAILABLE FOR COMMISARY SERVICES.

INMATE SIGNATURES ARE REQUIRED PRIOR TO SUBMITTING REQUESTS AND [illegible] THE SICK CALL PROCESS.

Russell Fautch
INMATE SIGNATURE

3-4-16
DATE

MEDICAL STAFF USE ONLY BELOW THIS BOX

RECEIVED BY MEDICAL:

MEDICAL SIGNATURE ________ DATE/TIME ________

ACTION TO BE TAKEN:

- ☐ SCHEDULE FOR SICK CALL
- ☐ SCHEDULE FOR PROVIDER CLINIC
- ☐ WRITTEN RESPONSE TO INQUIRY
- ☐ OTHER: ________

MEDICAL RESPONSE:

MEDICAL SIGNATURE ________ DATE/TIME ________

TURN KEY HEALTH

TURN KEY HEALTH

DENTAL - TOOTHACHE PROTOCOL

PATIENT NAME: Russell, Fourth DOB: [redacted] DATE: 3/5/16

ALLERGIES: NKDA

SUBJECTIVE: Toothache

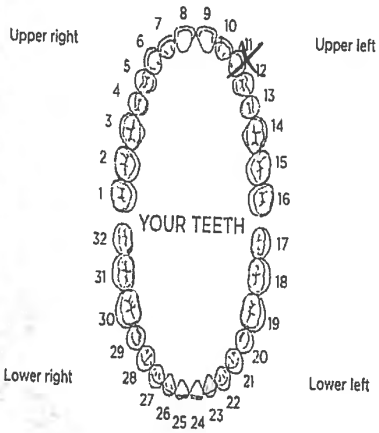
INITIAL COMPLAINT:

Onset: ☑ New ☐ Constant ☐ Intermittent

Pain Scale: (1-10) 6

Associated symptoms: ☑ Earache ☐ Jaw Pain ☐ Sinus ☐ Sore throat

Contributing factors to pain: ☐ Eating ☑ Drinking ☑ Chewing ☑ Hot ☑ Cold



OBJECTIVE:

BP	P	R	T	O2	Wt
134/87	77	20	97.7	98	210

ASSESSMENT:

Visual evidence of Tooth decay ☑ Yes ☐ No
Comments:

Reddness surrounding affected tooth ☑ Yes ☐ No
Comments:

Swelling surrounding affected tooth ☑ Yes ☐ No
Comments:

Visual evidence of external swelling ☑ Yes ☐ No
Comments:

Pus surrounding affected tooth ☑ Yes ☐ No
Comments:

Evidence of trauma/ injury to jaw ☐ Yes ☑ No
Comments:

Tooth positive to percussion ☐ Yes ☑ No
Comments:

Appearance : ☐ No distress ☐ Mild distress ☑ Moderate distress ☐ Severe distress

Amot

Notify Provider if:

☑ Signs of infection (swollen gums and jaw, reddness)
☐ Severe tooth pain not relieved by Ibuprophen or Tylenol
☐ Accidents with painful/fractured teeth, bleeding, or if can not close mouth
☐ Temperature greater than 100

PLAN: *Provider approval must be obtained prior to any prescription medication being given*

☐ Ibuprophen 400 mg po BID for no more than 7 days without Provider order
☐ Tylenol 1000mg po BID for no more than 7 days without Provider order.
☐ Tincture of Benzocaine Compound via swab topical to tooth BID for no more than 7 days without Provider order.

Patient Education:

☐ Instructed on proper oral hygiene care, medication use, follow-up sick call if no improvement.

Additional Orders: Amoxicillin 500mg po BID X 7 days & Ibu 800mg BID X 7d

Additional Comments:

Medical Staff Signature [signature] Date 3/5/16

SICK CALL REQUEST FORM

INMATE NAME: Russel Foutch DOB: [redacted] DOC # [redacted]

DATE: 8-5-16 FACILTY: CCJ LOCATION/POD: E-119

REASON FOR REQUEST:

Im DOC and need to go to Dent. bc Badly have very bad tooth that Hurts

1. INMATES ACCESSING MEDICAL, MENTAL HEALTH, DENTAL OR PHARMACEUTICAL SERVICES WILL BE CHARGED IN ACCORDANCE WITH OKLAHOMA STATUTES.
2. INMATES WILL NOT BE DENIED MEDICAL CARE DUE TO THE INABILITY TO PAY OR DUE TO INSUFFICIENT FUNDS IN THEIR INMATE ACCOUNT.
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INMATE SIGNATURES ARE REQUIRED PRIOR TO SUBMITTING REQUESTS, AND SIGNATURES ACKNOWLEDGE UNDERSTANDING OF THE SICK CALL PROCESS.

Russel Foutch — INMATE SIGNATURE

8-5-16 — DATE

MEDICAL STAFF USE ONLY BELOW THIS BOX

RECEIVED BY MEDICAL:

CCronLPN — MEDICAL SIGNATURE

8/5/16 — DATE/TIME

ACTION TO BE TAKEN:

☐ SCHEDULE FOR SICK CALL ☐ SCHEDULE FOR PROVIDER CLINIC ☐ WRITTEN RESPONSE TO INQUIRY

☐ OTHER: _____

MEDICAL RESPONSE:

Seen by nurse protocol noted

LaShadae LPN — MEDICAL SIGNATURE

8-7-16 — DATE/TIME

TURN KEY HEALTH

DOC

SICK CALL REQUEST FORM

INMATE NAME: Russell Foutch DOB: [redacted] INMATE NUMBER: [redacted]

DATE: 8-28-16 FACILITY: CCJC LOCATION/POD: E 119

REASON FOR REQUEST:

My tooth is causing me a lot of pain and I am having trouble eating I need it pulled out Thank you

1. INMATES ACCESSING MEDICAL, MENTAL HEALTH, DENTAL OR PHARMACEUTICAL SERVICES WILL BE CHARGED IN ACCORDANCE WITH OKLAHOMA STATUTES.
2. INMATES WILL NOT BE DENIED MEDICAL CARE DUE TO THE INABILITY TO PAY OR DUE TO INSUFFICIENT FUNDS IN THEIR INMATE ACCOUNT.
3. FEES FOR MEDICAL SERVICES WILL BE DEDUCTED DIRECTLY FROM AN INMATE'S ACCOUNT. IF THERE ARE INSUFFICIENT FUNDS IN THE ACCOUNT, THE FEES WILL BE DEBITED AND THE ACCOUNT WILL SHOW A NEGATIVE BALANCE. ANY MONEY DEPOSITED INTO AN ACCOUNT WITH A NEGATIVE BALANCE WILL BE USED TO SATISFY THE DEBT WITH THE FACILITY PRIOR TO BEING AVAILABLE FOR COMMISARY SERVICES.

INMATE SIGNATURES ARE REQUIRED PRIOR TO SUBMITTING REQUESTS, AND SIGNATURES ACKNOWLEDGE UNDERSTANDING OF THE SICK CALL PROCESS.

Russell Foutch — INMATE SIGNATURE

8-28-16 — DATE

MEDICAL STAFF USE ONLY BELOW THIS BOX

RECEIVED BY MEDICAL:

CGreen LPN — MEDICAL SIGNATURE

8/29/16 — DATE/TIME

ACTION TO BE TAKEN:

☒ SCHEDULE FOR SICK CALL ☐ SCHEDULE FOR PROVIDER CLINIC ☐ WRITTEN RESPONSE TO INQUIRY

☐ OTHER: _____

MEDICAL RESPONSE:

Seen by nurse 8/31/16 protocol noted.

LaShedae LPN — MEDICAL SIGNATURE

8/31/16 — DATE/TIME

TURN KEY HEALTH

TURN KEY HEALTH

DENTAL - TOOTHACHE PROTOCOL

PATIENT NAME: Foutch, Russell DOB: [redacted] DATE: 8/31/16

ALLERGIES: NKA

SUBJECTIVE: tooth pain

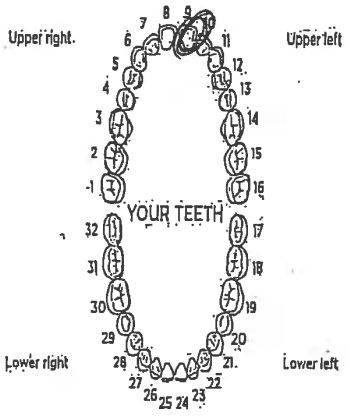
INITIAL COMPLAINT:

Onset: ☐ New ☒ Constant ☐ Intermittent

Pain Scale: (1-10) 7-8

Associated symptoms: ☐ Earache ☐ Jaw Pain ☐ Sinus ☐ Sore throat

Contributing factors to pain: ☒ Eating ☐ Drinking ☒ Chewing ☐ Hot ☐ Cold



OBJECTIVE:

BP 142/100	P 63	R 18	T 97.3	O2 98	Wt

ASSESSMENT:

Visual evidence of Tooth decay ☐ Yes ☒ No
Comments:

Reddness surrounding affected tooth ☒ Yes ☐ No
Comments:

Swelling surrounding affected tooth ☐ Yes ☒ No
Comments:

Visual evidence of external swelling ☐ Yes ☒ No
Comments:

Pus surrounding affected tooth ☐ Yes ☒ No
Comments:

Evidence of trauma/ injury to jaw ☐ Yes ☒ No
Comments:

Tooth positive to percussion ☐ Yes ☐ No
Comments:

Appearance : ☐ No distress ☒ Mild distress ☐ Moderate distress ☐ Severe distress

Notify Provider if:

- ☐ Signs of infection (swollen gums and jaw, reddness)
- ☐ Severe tooth pain not relieved by Ibuprophen or Tylenol
- ☐ Accidents with painful/fractured teeth, bleeding, or if can not close mouth
- ☐ Temperature greater than 100

PLAN: *Provider approval must be obtained prior to any prescription medication being given*

- ☒ Ibuprophen 400 mg po BID for no more than 7 days without Provider order
- ☐ Tylenol 1000 mg po BID for no more than 7 days without Provider order.
- ☐ Oragel topically BID for no more than 7 days without Provider order.

Patient Education:

- ☐ Instructed on proper oral hygiene care, medication use, follow-up sick call if no improvement.

Additional Orders:

Additional Comments:

Medical Staff Signature LaShadae Lpn Date 8/31/16

TURN KEY HEALTH

MEDICAL PROTOCOL

SHORTNESS OF BREATH

PATIENT NAME: Foutch, Russell DATE: 9/28/16

Subjective Data: Wheezing c̄ deep breaths + coughing trying to breath deeply
Allergies: NKA
Initial Complaint: Difficulty breathing, episodes of fainting, ⊖ appetite

Onset: ☐ New ☐ Chronic ☑ Recurrence Severity of attack: (1-10) 8

Current Medications: Several

Precipitating Factors: ☐ Cold Air ☐ Exercise ☐ Air pollutants ☐ Chemicals ☑ Asthma ☐ COPD ☐ Resp Inf ☐ CHF

Associated symptoms: ☐ Productive Cough Explain: ☑ Wheezing

Objective Data: Peak Flow:

P 145/105	T 97.8	P 97	R 20	O2 92 – 95

Respiration	Skin	Appearance	LOC	Swelling	Lungs
☑ Even	☐ Warm	☐ No distress	☐ Awake	☐ Extremities Ø	☐ Clear
☐ Uneven	☐ Pink	☑ Mild distress	☑ Alert	☐ Generalized	☐ Rhonchi
☑ Labored	☑ Cool	☐ Severe Distress	☑ Oriented x 3	☐ Pitting	☐ Rales
☐ Unlabored	☑ Pale		☐ Confused		☑ Wheezes
☑ Shallow	☐ Cyanotic		☐ Lethargic		☐ Crackles
Deep	☐ Mottled		☐ Comatose		☑ Diminish Ⓡ side
☐ Rapid					

Assessment:
Impaired gas exchange related to reactive airway disease.

Plan: *Provider approval must be obtained prior to any prescription medication being administered.*

NOTIFY MEDICAL PROVIDER IMMEDIATELY IF:
Severe exacerbation ☐ Unstable ☐ Unresponsive to treatment
O 2 sat of < 87 % or < 90 % following treatment
Use inhaler (usually albuterol) for symptomatic treatment If patient has own inhaler.
If patient does not have inhaler or if not responsive to inhaler treatment in 10 minutes administer Nebulizer Treatment with Albuterol 0.5 ml prepackaged Normal saline (this will require order from Provider)
Evaluate frequently every 15 -30 minutes. Encourage fluids.
Initiate O 2 at 6 liter / min administered by non-rebreathing mask if in acute distress/ shortness of breath.
If does not respond to treatment call ambulance for transport to hospital and notify Provider.
If patient does respond to treatment schedule for next Provider clinic.

Additional orders:

Patient Education:
☑ Instructed to increase fluids, factors that trigger asthma attack, correct use of inhaler, follow-up sick call if no improvement. patient verbalizes understanding.

Additional Notes:
Albuterol neb tx given O² ↑ to 95% after. Ⓡ side lungs diminished + wheezing heard. c/o chest pain c̄ deep breathing. BS 130.

Medical staff Signature: [signature] LPN Date: 9/28/16

Conf Looks to see MOU

CONFIDENTIAL TK017

MEDICAL PROGRESS NOTE FORM

(ALL PATIENT ENCOUNTERS REQUIRE SOAPE FORMAT)

NAME: Foutch, Russell DOB [redacted] SS/INMATE# _____

ALLERGIES NKDA

DATE/TIME	CLINICAL NOTE
9-29-16	1400 Note left for this nurse by LPN C. Green, requesting a call be made to the provider about treatment for the inmate. Inmate has done 2 sick calls this week for shortness of breath, wheezing & dizziness. Provider L. Goatley ARNP ordered to continue the albuterol nebulizer treatments ordered on 9-25-16 & that she will see him Monday in clinic as long as the symptoms do not worsen. 136/92, HR-94, SpO2-94%, T 98°, RR 22. Will cont to monitor. — Broom LPN
9-30-16	1115 Inmates called guards to E-pod to check on inmate Foutch. Per DO Conner, the inmate was cyanotic and not breathing. Inmate was aroused and brought to medical. In the hallway outside booking, the inmate became dizzy and collapsed to the floor. At this time EMS was called by Supervisor Smithtc respond to the facility. — Broom LPN
9-30-16	1120 This nurse encountered inmate lying in the floor with DOs around him. Inmate was alert & somelethargy Able to answer questions appropriately. Inmate diaphoretic and pale in color. VS 132/92, HR 119, SpO2 93%, RR 24, 0 nitro or any meds given as this nurse notified EMS was at facility. — Broom LPN
9-30-16	1125 EMS personnel encounter pt still lying down →

TURN KEY HEALTH

MEDICAL PROGRESS NOTE FORM

(ALL PATIENT ENCOUNTERS REQUIRE SOAPE FORMAT)

NAME: Fowler, Russell DOB: [redacted] S/INMATE#

ALLERGIES NKDA

DATE/TIME	CLINICAL NOTE
9-30-16 1125 (Contd.)	in hallway outside booking. Inmate still able to answer EMT questions and get to gurney with assist. As inmate was being loaded into the ambulance his eyes rolled back into his head and his vital signs crashed. A code was initiated by EMS personnel ~~& CPR~~ on the ambulance. NLPN
9-30-16	1155 After performing several rounds of CPR on inmate, EMS departed CCSC for St. John's Hospital - Sapulpa still performing CPR. — NLPN Nicholas Groom, LPN
9-30-16 Late entry	0900 Inmate was informed this AM that the provider would see him Monday if symptoms did not worsen. Inmate agreed & had no complaints at this time. NLPN

TURN KEY HEALTH

TURN KEY HEALTH

PROVIDER ORDERS

NAME: Foutch, Russell DOB: [redacted] S/INMATE#_____

ALLERGIES NKDA

DATE/TIME	PROVIDER ORDERS	NOTED BY / DATE / TIME
2/22/16 1651	Lamictal 25 mg po @ HS Remeron 45 mg po @ HS Risperidone 1mg PO # @ HS Celexa 20mg po @ HS Tablets Courtesy APRN	Courtney APRN-C

TURN KEY HEALTH

PROVIDER ORDERS

NAME: Faith, Russel DOB [redacted] S/INMATE#
ALLERGIES NKDA

DATE/TIME	PROVIDER ORDERS	NOTED BY / DATE / TIME
5/5/16 1400	Amoxicillin 500mg PO BID X 7 days Ibuprofen 800mg PO BID X 7 days T/O left knee pain	Courtney, ARNP

TURN KEY HEALTH D.O.C.

Medical Protocols

Upper Respiratory Congestion (Common Cold)

PATIENT NAME: Fauten, Russell DATE: 9-25-16

Subjective Data:

Allergies: NKDA

Initial Complaint: ~~BID albuterol~~ SOB

History of: ☐ Asthma ☐ COPD ☐ Sinus infection ☐ Past positive PPD ☒ Night sweats

Onset: ☒ New onset ☐ Chronic ☐ Recurrence

Current Medications:

Objective Data:

BP 158/99	P 117	R 20	T 96.8	O2 98%

Associated symptoms: ☐ Fever ☐ Red eyes ☐ Itchy eyes ☐ Stuffy nose ☒ Runny nose ☐ Sneezing

☒ Productive cough ☐ Non-Productive cough Describe: Pinkish phelm

Smoking History ☐ Current ☒ Previous Packs per day? 2 packs Last use? 7/mone

Throat	☐ Normal	☒ Red / Inflamed	☐ White / patchy	☐ Pustules	☐ Clear drainage
Lungs (Rt)	☐ Clear	☐ Crackles	☐ Wheezing	☐ Rhonchi	☐ Diminished
Lungs (Lt)	☐ Clear	☐ Crackles	☐ Wheezing	☐ Rhonchi	☐ Diminished
Nasal	☒ Normal	☐ Red / Inflamed	☐ Swollen	☐ Tonsils	☐ Yellow / green discharge
Neck gland	☒ Normal	☐ Swollen	☐ Tender to palpitation		
Ears	☒ Normal	☐ Red	☐ Drainage Describe:		☐ Chronic
COPD	☐ Yes	☒ No	**Congestive Heart Failure**	☐ Yes	☒ No

Assessment:

☒ Alteration in comfort related to mild upper respiratory congestion.

Plan:

Provider approval must be obtained prior to any prescription medication administered.

☐ Notify Provider if symptoms of TB: night sweats, weight loss, productive cough, fever

☐ Notify Provider temperature above 102 degrees F.

☐ Notify Provider if lymphadenopathy present

☐ There are symptoms or concerns of secondary bacterial infection: green or yellow purulent sputum or drainage from nose, ear pain, dyspnea.

☐ There is a history of severe COPD

☒ Nasal drainage may give CTM 4 mg po BID for no more than 7 days without Providers order

☒ Mild congestion may give Mucus Relief 1 tablet BID for no more than 3 days without Provider order. when available

☒ May give Tylenol 1000mg po bid or Ibuprophen 400 mg po BID for pain or elevated temperature for no more than 7 days without Provider order prn

ADDITIONAL ORDERS:

Albuterol Neb. tx Bid PRN -

Patient Education:

☒ Instructed patient to increase fluids, medication use, follow-up sick call if no improvement. Verbalized understanding.

Medical staff Signature: LaShadae LPN Date: 9-25-16

TURN KEY HEALTH

PROVIDER ORDERS

NAME: Foutch, Russell DOB [redacted] SS/INMATE#_____

ALLERGIES NKDA

DATE/TIME	PROVIDER ORDERS	NOTED BY / DATE / TIME
5/20/16 1900	Lamictal 25mg PO @ HS Remeron 45mg PO @ HS Risperidal 2mg @ HS Celexa 20mg PO @ HS T.O. Lela Goatley ARNP	CCranisPN 5/20/16 1900 L Goatley APRN
9-25-16 1415	Albuterol Neb tx Bid PRN T.O. Lela Goatley ARNP/L6	LaShadre LPN Goatley APRN

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR
ORIGINAL ORDER 2/22/16 DISCONTINUE 5/20/16	Lamictal 25mg PO @ HS Gaetley/cg	PM
ORIGINAL ORDER 5/20/16 DISCONTINUE	Remeron 45mg PO @ HS Gaetley/cg	PM
ORIGINAL ORDER 5/20/16 DISCONTINUE	Risperidal 2mg PO @ HS Gaetley/cg	PM
ORIGINAL ORDER 5/20/16 DISCONTINUE	Celexa 20mg PO @ HS Gaetley/cg	PM
ORIGINAL ORDER DISCONTINUE		PM
ORIGINAL ORDER DISCONTINUE		PM

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
				LG	LaShundra LPN				

LOCATION E

DATE OF BIRTH OR SOC. SEC. NO. [redacted]

ALLERGIES NKDA

DIAGNOSIS

PATIENT NAME AND NUMBER Fautch, Russell

FACILITY

CHARTING FOR

THROUGH

CONFIDENTIAL

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
- CIRCLE INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.
- STATE REASON FOR REFUSAL UNDER MEDICATION NOTES.
- STATE REASON AND RESULT FOR PRN MEDICATION OR TREATMENT.
- INDICATE INJECTION SITE WITH APPROPRIATE CODE.

Injection Site Codes:

1. ABDOMEN LEFT
2. ABDOMEN RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. BUTTOCKS (GLUTEUS) LEFT
6. BUTTOCKS (GLUTEUS) RIGHT
7. THIGH (QUADRICEPS) LEFT
8. THIGH (QUADRICEPS) RIGHT
9. UPPER BACK LEFT
10. UPPER BACK RIGHT
11. UPPER CHEST LEFT
12. UPPER CHEST RIGHT

Result Codes:

A. EFFECTIVE
B. SLIGHTLY EFFECTIVE
C. INEFFECTIVE
D. NO EFFECT OBSERVED

Non Administered Medication Reason Codes:

1. REFUSED BY PATIENT
2. PATIENT DID NOT SHOW
3. PATIENT NOT IN CELL
4. SECURITY LOCKDOWN
5. MEDICATION HELD (STATE REASON)
6. MEDICATION OUT OF STOCK

Date	Time	Init.	Medication - Dose	Route	Reason	Result	Date	Time	Init.	Medication - Dose	Route	Reason	Result

CONFIDENTIAL

DIAM-025

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR
ORIGINAL ORDER / DISCONTINUE	Lamictal 25mg PO @ HS Lela Goatley Amp	AM / PM
ORIGINAL ORDER / DISCONTINUE	Remeron 45mg PO @ HS Lela Goatley Amp	HS
ORIGINAL ORDER / DISCONTINUE	Risperidal ~~2mg~~ error 1mg PO @ HS Lela Goatley Amp	PM
ORIGINAL ORDER / DISCONTINUE	Celexa 20mg PO @ HS	PM
ORIGINAL ORDER / DISCONTINUE	Ibuprofen 800mg PO BID x 7 days Goatley	AM / PM Start 1 2 3 4 5 6 7 Stop
ORIGINAL ORDER / DISCONTINUE	Amox 500mg PO BID x 2 days Goatley	AM / PM Start Stop

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature

LOCATION: E Pod
DATE OF BIRTH OR SOC. SEC. NO.: [redacted]
ALLERGIES: NKDA
DIAGNOSIS:
PATIENT NAME AND NUMBER: Loutch, Russell
FACILITY: CCCJC
CHARTING FOR: March 2016
THROUGH:

CONFIDENTIAL

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
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CONFIDENTIAL

DIAM-025

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR
ORIGINAL ORDER 2/22/16 DISCONTINUE 2/21/16	Lamictal 25mg PO ÷ @ HS Tela Goatley ARNP	HS
ORIGINAL ORDER 2/22/16 DISCONTINUE 2/21/16	Remeron 45mg ÷ @ HS Tela Goatley ARNP	HS
ORIGINAL ORDER 2/22/16 DISCONTINUE 2/21/16	Risperdal 2mg PO @ HS Tela Goatley ARNP	HS
ORIGINAL ORDER 2/22/16 DISCONTINUE 2/21/16	Celexa 20mg PO @ HS Tela Goatley ARNP	HS
ORIGINAL ORDER		
DISCONTINUE		
ORIGINAL ORDER		
DISCONTINUE		

Case for renewal

Case for renewal

Case for renewal

Case for renewal

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
						CJ	CJR SPV		

LOCATION F

DATE OF BIRTH OR SOC. SEC. NO. [redacted]

ALLERGIES NKDA

DIAGNOSIS

PATIENT NAME AND NUMBER Foutch, Russell

FACILITY CCCJC

CHARTING FOR May 2016. THROUGH

CONFIDENTIAL

MEDICATION NOTES

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- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
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CONFIDENTIAL

DIAM-025

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER 5-20-16	Lamictal 25mg ½ @ HS		1	2	3	4	5		7	8	9	10	11	12	13	14	15		17	18	19	20	21	22	23	24	25	26	27	28	29	30	
DISCONTINUE	Goatley	PM	cg	LG	cg	cg	cg	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	cg	LG	LG	LG	cg	cg	cg	LG	LG	cg	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER 5-20-16	Remeron 45 mg ½ @ HS		1	2	3	4	5	6	7	8	9		11	12		14	15	16		18	19	20	21	22	23	24	25	26		28	29	30	31
DISCONTINUE		PM	cg	LG	cg	cg	cg	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	cg	LG	LG	LG	cg	cg	cg	LG	LG	cg	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER 5-20-16	Risperidal 2mg ½ PO @ HS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18		20	21	22	23	24	25	26		28	29	30	31
DISCONTINUE		PM	cg	LG	cg	cg	cg	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	cg	LG	LG	LG	cg	cg	cg	LG	LG	cg	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER 5-20-16	Celexa 20mg ½ PO @ HS		1	2	3	4	5	6	7	8	9		11	12	13	14			17	18	19	20	21	22	23	24	25	26		28	29	30	
DISCONTINUE		PM	cg	LG	cg	cg	cg	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	LG	cg	LG	cg	LG	LG	LG	cg	cg	cg	LG	LG	cg	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	1	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DISCONTINUE			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21		23	24	25	26	27	28	29	30	31
DISCONTINUE			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
		CG	C Green LPN	LG	L Shadle LPN				

LOCATION: E
DATE OF BIRTH OR SOC. SEC. NO.: [redacted]
ALLERGIES: NKDA
DIAGNOSIS:
PATIENT NAME AND NUMBER: Foutch, Russell
FACILITY: CCJC
CHARTING FOR: June '16
THROUGH:

CONFIDENTIAL

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
- CIRCLE INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.
- STATE REASON FOR REFUSAL UNDER MEDICATION NOTES.
- STATE REASON AND RESULT FOR PRN MEDICATION OR TREATMENT.
- INDICATE INJECTION SITE WITH APPROPRIATE CODE.

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Result Codes:

A. EFFECTIVE
B. SLIGHTLY EFFECTIVE
C. INEFFECTIVE
D. NO EFFECT OBSERVED

Non Administered Medication Reason Codes:

1. REFUSED BY PATIENT
2. PATIENT DID NOT SHOW
3. PATIENT NOT IN CELL
4. SECURITY LOCKDOWN
5. MEDICATION HELD (STATE REASON)
6. MEDICATION OUT OF STOCK

Date	Time	Init.	Medication - Dose	Route	Reason	Result	Date	Time	Init.	Medication - Dose	Route	Reason	Result

CONFIDENTIAL

DIAM-025

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR
ORIGINAL ORDER 5-20-16 / DISCONTINUE	Lamictal 25mg ½ @HS Gentley	HS
ORIGINAL ORDER 5-20 / DISCONTINUE	Remeron 45mg ½ @HS	HS
ORIGINAL ORDER 5-20 / DISCONTINUE	Risperidal 2mg ½ PO @HS	HS
ORIGINAL ORDER 5-20 / DISCONTINUE	Celexa 20mg ½ PO @HS	HS
ORIGINAL ORDER / DISCONTINUE		
ORIGINAL ORDER / DISCONTINUE		

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
				NB	LPN	LG	LaShadae LPN	M	Jackson LPN

LOCATION E

DATE OF BIRTH AND SEX [redacted]

ALLERGIES NKDA

DIAGNOSIS

PATIENT NAME AND NUMBER Fourth, Russell

FACILITY CCJC

CHARTING FOR [illegible] THROUGH July '16

CONFIDENTIAL

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
- CIRCLE INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.
- STATE REASON FOR REFUSAL UNDER MEDICATION NOTES.
- STATE REASON AND RESULT FOR PRN MEDICATION OR TREATMENT.
- INDICATE INJECTION SITE WITH APPROPRIATE CODE.

Injection Site Codes:

1. ABDOMEN LEFT
2. ABDOMEN RIGHT
3. ARM (DELTOID) LEFT
4. ARM (DELTOID) RIGHT
5. BUTTOCKS (GLUTEUS) LEFT
6. BUTTOCKS (GLUTEUS) RIGHT
7. THIGH (QUADRICEPS) LEFT
8. THIGH (QUADRICEPS) RIGHT
9. UPPER BACK LEFT
10. UPPER BACK RIGHT
11. UPPER CHEST LEFT
12. UPPER CHEST RIGHT

Result Codes:

A. EFFECTIVE
B. SLIGHTLY EFFECTIVE
C. INEFFECTIVE
D. NO EFFECT OBSERVED

Non Administered Medication Reason Codes:

1. REFUSED BY PATIENT
2. PATIENT DID NOT SHOW
3. PATIENT NOT IN CELL
4. SECURITY LOCKDOWN
5. MEDICATION HELD (STATE REASON)
6. MEDICATION OUT OF STOCK

Date	Time	Init.	Medication - Dose	Route	Reason	Result	Date	Time	Init.	Medication - Dose	Route	Reason	Result

CONFIDENTIAL

DIAM-025

TK033

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR
ORIGINAL ORDER 5-20-16 / DISCONTINUE	Lamictal 25mg ½ @ HS Gouty	HS
ORIGINAL ORDER 5-20 / DISCONTINUE	Remeron 45mg ½ @ HS	HS
ORIGINAL ORDER 5-20 / DISCONTINUE	Risperidal 2mg ½ PO @ HS	HS
ORIGINAL ORDER 5-20 / DISCONTINUE	Celexa 20mg ½ PO @ HS	HS
ORIGINAL ORDER 8/7 / DISCONTINUE	~~Ibuprofen 400mg PRN~~ x 7days	AM PM
ORIGINAL ORDER / DISCONTINUE		

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
				LG	LaShadae LPN	LG			

LOCATION E | DATE OF BIRTH OR SOC. SEC. NO. [redacted] | ALLERGIES NKDA | DIAGNOSIS

PATIENT NAME AND NUMBER Foutch, Russell | FACILITY CCSC | CHARTING FOR Aug '16 THROUGH

CONFIDENTIAL

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
- CIRCLE INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.
- STATE REASON FOR REFUSAL UNDER MEDICATION NOTES.
- STATE REASON AND RESULT FOR PRN MEDICATION OR TREATMENT.
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8. THIGH (QUADRICEPS) RIGHT
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10. UPPER BACK RIGHT
11. UPPER CHEST LEFT
12. UPPER CHEST RIGHT

Result Codes:

A. EFFECTIVE
B. SLIGHTLY EFFECTIVE
C. INEFFECTIVE
D. NO EFFECT OBSERVED

Non Administered Medication Reason Codes:

1. REFUSED BY PATIENT
2. PATIENT DID NOT SHOW
3. PATIENT NOT IN CELL
4. SECURITY LOCKDOWN
5. MEDICATION HELD (STATE REASON)
6. MEDICATION OUT OF STOCK

Date	Time	Init.	Medication - Dose	Route	Reason	Result	Date	Time	Init.	Medication - Dose	Route	Reason	Result

CONFIDENTIAL

DIAM-025

TK035

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR
ORIGINAL ORDER / DISCONTINUE	Lamictal 25mg PO @ HS Coatley	AM
ORIGINAL ORDER / DISCONTINUE	Remeron 45mg PO @ HS Coatley	PM
ORIGINAL ORDER / DISCONTINUE	Risperdal 2mg PO @ HS Coatley	PM
ORIGINAL ORDER / DISCONTINUE	celexa 20mg PO @ HS Coatley	PM
ORIGINAL ORDER 8/31/16 / DISCONTINUE	Ibuprofen 400mg PO BID x 7 days	AM PM
ORIGINAL ORDER 9/25/16 / DISCONTINUE	Neb ~~tx~~ 1 vial B.id PRN Coatley/LG	PRN PRN

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
				LG	LaShadee LPN				

LOCATION: E
DATE OF BIRTH OR SOC. SEC. NO.: [redacted]
ALLERGIES: NKDA
CHARTING FOR: Sept 2016
THROUGH:
DIAGNOSIS:
PATIENT NAME AND NUMBER: Fourtch, Russell
FACILITY: CCTC

1 of 2

CONFIDENTIAL

TK036

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
- CIRCLE INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.
- STATE REASON FOR REFUSAL UNDER MEDICATION NOTES.
- STATE REASON AND RESULT FOR PRN MEDICATION OR TREATMENT.
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8. THIGH (QUADRICEPS) RIGHT
9. UPPER BACK LEFT
10. UPPER BACK RIGHT
11. UPPER CHEST LEFT
12. UPPER CHEST RIGHT

Result Codes:

A. EFFECTIVE
B. SLIGHTLY EFFECTIVE
C. INEFFECTIVE
D. NO EFFECT OBSERVED

Non Administered Medication Reason Codes:

1. REFUSED BY PATIENT
2. PATIENT DID NOT SHOW
3. PATIENT NOT IN CELL
4. SECURITY LOCKDOWN
5. MEDICATION HELD (STATE REASON)
6. MEDICATION OUT OF STOCK

Date	Time	Init.	Medication - Dose	Route	Reason	Result	Date	Time	Init.	Medication - Dose	Route	Reason	Result

CONFIDENTIAL

DIAM-025

TK037

MEDICATION ADMINISTRATION RECORD

DIAMOND PHARMACY SERVICES
1.800.882.6337 FAX: 724.349.4209

EFFECTIVE DATES	MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ORIGINAL ORDER 9/27/16	CTM 4mg PO Bid x7d.																																
		Am																															
DISCONTINUE																																	
	OTC Allergy	Am																											LG	cg	LG		
ORIGINAL ORDER																																	
DISCONTINUE																																	
ORIGINAL ORDER																																	
DISCONTINUE																																	
ORIGINAL ORDER																																	
DISCONTINUE																																	
ORIGINAL ORDER																																	
DISCONTINUE																																	
ORIGINAL ORDER																																	
DISCONTINUE																																	

Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature	Initial	Signature
				LG	Lahadae Lpn				

LOCATION: E
DATE OF BIRTH OR SOC. SEC. NO.: [redacted]
ALLERGIES: NKDA
DIAGNOSIS: 2 of 2
PATIENT NAME AND NUMBER: Fatch, Russell
FACILITY: CCCJC
CHARTING FOR: Sept.
THROUGH: 2016

TK038

CONFIDENTIAL

MEDICATION NOTES

Instructions:

- INITIAL APPROPRIATE BOX WHEN MEDICATION OR TREATMENT IS GIVEN.
- CIRCLE INITIALS WHEN MEDICATION OR TREATMENT IS REFUSED.
- STATE REASON FOR REFUSAL UNDER MEDICATION NOTES.
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5. MEDICATION HELD (STATE REASON)
6. MEDICATION OUT OF STOCK

Date	Time	Init.	Medication - Dose	Route	Reason	Result	Date	Time	Init.	Medication - Dose	Route	Reason	Result

CONFIDENTIAL

P. 1

* * * Communication Result Report (Oct. 19. 2016 2:38PM) * * *

1)
2)

Date/Time: Oct. 19. 2016 2:37PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
3366	Memory TX	14055639131	P. 1	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size
E. 6) Destination does not support IP-Fax

TURN KEY HEALTH

OFFSITE NOTIFICATION

Date: ~~9-30-16~~ 10-9-30-16 Time: 1230 Facility: Creek Co.

PATIENT NAME: Foutch, Russell SS#/INMATE#: [redacted]

CUSTODY STATUS: County ☐ Municipal ☐ DOC ☒ Prior to Booking ☐ Federal ☐ Other ☐

TYPE OF SERVICE: Dental ☐ Consultation Visit ☐ ER Visit ☒

FACILITY SENT TO: St. John's Sapulpa

TRANSPORT: AMBULANCE ☒ CCEMS DEPUTY ☐ OTHER

DIAGNOSIS/SUSPECTED CONDITION: Fainting, Diaphoretic (sweating through his shirt), Chest pain

Mutual Combat: Yes ☐ No ☒

Was this injury caused by any Acts or Omission of the County: Yes ☐ No ☒

IS THIS PRE-EXISTING: YES ☒ NO ☐

PROVIDER NOTIFIED: YES ☒ NO ☐ PROVIDERS NAME: Leela Gautta, ARNP

INMATES MAILING ADDRESS Or Next of Kin 357620 E 760 Rd Cushing, OK 74023

NAME OF THE STAFF TRANSFERING Nicholas Groom

SIGNATURE N Groom CPN DATE ~~9-30-16~~ 10-9-30-16

Inmate Pronounced deceased at Hospital 12:20pm, 9-30-16

COMPLETE IMMEDIATELY AFTER TRANSPORT FAX TO 405-563-9131**

7-21-16

TURN KEY HEALTH

OFFSITE NOTIFICATION

Date: 9th 9-30-16 Time: 1230 Facility: Creek Co.

PATIENT NAME: Foutch, Russell SS#/INMATE#: [redacted]

CUSTODY STATUS: County ☐ DOC ☒ Federal ☐
Municipal ☐ Prior to Booking ☐ Other ☐

TYPE OF SERVICE: Dental ☐ Consultation Visit ☐ ER Visit ☒

FACILITY SENT TO: St. John's Sapulpa

TRANSPORT: AMBULANCE ☒ CCEMS DEPUTY ☐ OTHER ____

DIAGNOSIS/SUSPECTED CONDITION: Fainting, Diaphoretic (sweating through his shirt), Chest pain

Mutual Combat: Yes ☐ No ☒

Was this injury caused by any Acts or Omission of the County: Yes ☐ No ☒

IS THIS PRE-EXISTING: YES ☒ NO ☐

PROVIDER NOTIFIED: YES ☒ NO ☐ PROVIDERS NAME: Leela Goatley, ARNP

INMATES MAILING ADDRESS Or Next of Kin 357620 E 760 Rd
Cushing, OK 74023

NAME OF THE STAFF TRANSFERING Nicholas Groom

SIGNATURE N Groom LPN DATE 9th 9-30-16

Inmate Pronounced deceased at Hospital 12:20pm, 9-30-16

****COMPLETE IMMEDIATELY AFTER TRANSPORT** FAX TO 405-563-9131****

7-21-16